[primary health care] as a model lessons learned

advancing
PRIMARY HEALTH CARE IN ALBERTA
sharing the learning

What is primary health care (PHC)?

Primary health care is the first point of contact of individuals with the health system – this is where health services are accessed and basic services to meet health, preventative, care and treatment needs are usually provided. Personal home or family care is usually also included.

Primary health care services include health promotion and basic prevention, preventive health assessments, treatment in physicians' offices, community nurse visits, nutritional counselling, drug dispensing, home care and so on. It involves a variety of health professionals working with physicians, nurses, public health nurses, nurse practitioners, pharmacists, mental health therapists, rehabilitation therapists, community workers, home care providers, social workers and others.

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The Umbrella Alberta Primary Health Care Project was created to further advance primary health care by informing the practice of primary health care in Alberta and future policy development.

PREFACE

The Umbrella Alberta Primary Health Care Project finds its roots in the final report of the National Forum on Health (1997). The report recommended reform in key areas, including primary health care. It further recommended creation of a health transition fund to support evidence-based pilot and evaluation projects in health care. In response to those recommendations, the federal government created the Health Transition Fund (HTF) in 1997. It focused on four key areas:

- primary health care reform;
- integrated delivery of services;
- home care; and
- pharmacare.

Following consultation with stakeholders in 1997, Alberta Health and Wellness chose to focus on primary health care and submitted a proposal to the federal government. Alberta received an $11.2 million HTF grant in 1998 from the federal government, and the Umbrella Alberta Primary Health Care Project was created. An external selection committee reviewed primary health care project proposals from across the province and 27 were ultimately recommended for funding. Most of the projects began in September 1998 and were completed by May 2000. Extensive dissemination activities by the Umbrella Alberta Primary Health Care Project, and its 27 funded projects commenced in August 2000, including a provincial showcase conference and the development of diverse products to disseminate the learning. Detailed information on each of the 27 projects can be found at: **www.health.gov.ab.ca/key/phc/index.htm**

SHARING THE LEARNING

While the projects were diverse, a number of common themes emerged from the final project reports and evaluation reports. Key findings in the areas of primary health care delivery, integration, multi-disciplinary teams, access and quality were compiled in a series of booklets, as well as other publications, designed to share the findings provincially and nationally as a contribution to the advancement of primary health care.

This stand-alone booklet documents the key findings from Alberta's primary health care projects that support the value of primary health care as a service delivery model.

The other materials can be obtained through Communications Branch, Alberta Health and Wellness, 22 Floor, Telus Plaza North Tower, 10025 Jasper Avenue, Edmonton, Alberta T5J 2N3. Telephone 780-427-7164.

Alberta Health and Wellness extends its thanks to the project teams, regional health authorities, partners, the evaluation management team (Howard Research Inc.) and the independent evaluation teams for their work in advancing primary health care in Alberta. It also thanks R.A. Malatest & Associates Ltd. and Dr. Leslie Gardner, who contributed to the development of this booklet, and our designers, Vision Design Communications Inc.

[what is] primary health care?

Primary health care is **not a new concept**. In rural communities, remote areas, inner cities and in numerous clinical practices and public health services, primary health care has been practiced in one form or another for many years. It is the **first point of contact** that people have with the health system and it is usually the **first level of care**.

Primary health care is based on a holistic definition of health.

In recent years, however, primary health care has increasingly involved a range of health providers and a focus on a multi-disciplinary approach to care. It now reflects a more comprehensive approach to health and well-being.

Primary health care is based on a holistic definition of health that recognizes the influence of social, economic and environmental factors on a person's well-being (Howard Research Inc., Monograph). Primary health care is delivered by a variety of providers and emphasizes the coordination of services, health promotion, illness and injury prevention, as well as care for episodic illness and for chronic conditions.

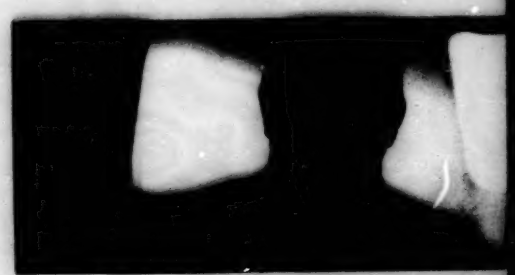
In this booklet, we explore the concept of primary health care and summarize the experiences of Alberta's 27 primary health care projects in implementing primary health care as a model.

"I remember one (community) meeting in particular where everybody was just sitting around the table waiting for some big announcement to happen. The regional health authority wanted to come and talk to community leaders, so right away, there was concern. But there was also hope about what this would bring them in terms of services to the community.

"People kept saying to us, 'What is this?' But primary health care is not a concrete thing. It is a concept. They said, 'Show me the brochure,' 'Where is this leading?' 'Does this mean we're going to have a walk-in clinic?' People needed something concrete and we were unable to give that to them at the outset, because what we were there to talk about was partnerships.

"When we talk about partnerships, what we usually mean is that we want you to partner with us to do what's on our agenda. And if that's the case, it isn't going to work. You have to be prepared to go out with the sole purpose of serving people in the community better. If you don't have that orientation, you will end up with something that falls short of what primary health care is about. It's got to be about genuine partnerships, not the region imposing its agenda on the community. The biggest gain is ultimately what the community can do for itself."

Steve Petz, CEO, East Central Health Authority, Primary Health Services Initiative (This project established integrated primary health services in four rural communities.)



Steve Petz

[common] ground

Although it may take many forms, **primary health care follows a set of principles.** A list of principles was identified in a major review of Canadian and international documents on primary health care over the last five years.

PRINCIPLES OF PRIMARY HEALTH CARE

The following list of principles was revised based on feedback from regional health authorities, service providers and professional associations:

1. to encourage and facilitate individuals and communities to become as healthy as possible, recognizing the central importance of the broad determinants of health;
2. to promote and facilitate the participation of individuals and communities to take greater responsibility for their own health;
3. to focus on the specific needs, strengths, resources and issues facing a community in determining the service mix and how, when and where to offer services;
4. to deliver affordable, reliable and timely services accessible to community members according to their needs;
5. to respond to the priority health needs of the population, systematically identifying those at risk, and to reduce inequities in health status;
6. to use multiple strategies in addressing individual and population health issues. This includes community development approaches, inter-disciplinary teams in collaboration with volunteers and other agencies, and the use of non-traditional and alternative health workers as appropriate;
7. to provide seamless transition and integrated care delivery by effectively linking primary health care and secondary care;
8. to use appropriate and affordable technology and tools in conjunction with information systems management and linkages, to ensure continuous quality improvement, ongoing education, proper evaluation and research; and
9. to be accountable to community members, providers, regional health authorities and governments for the development and practice of sustainable and affordable primary health care.

SYSTEM-WIDE CHALLENGES

The concept of primary health care is intrinsically appealing. As one CEO noted, the idea is not a tough sell, but the inherent structure of the health care system presents challenges to the implementation of primary health care. The pilot and evaluation projects identified the following challenges that must be addressed to successfully implement primary health care:

- the traditional organizational structure limits the ability of various sectors to work together;
- payment or reimbursement systems and incentives restrict compensation for care delivery;
- project funding is short term by nature and limits the impact on provider and community commitment.

organizational structure

The health care system in Alberta is organized into geographic regions. In many of these regions, the organizational structure is traditional and is defined by particular services (such as diagnostic imaging and home care) or by professional groups (e.g. nursing). Where this is the case, members of a collaborative, multi-disciplinary or inter-disciplinary team may report to different supervisors and levels of management, and may operate under different mandates and restrictions.

"The staff participating in service model development came to realize their services were defined by historical program mandates and established practices, not necessarily by the health needs of the community."

Final Report, Airdrie Community Health Centre Evaluation Project

"Within the home care organizational environment, coverage of staff was difficult for a variety of reasons:... the relationship between employer and the case managers is governed by a collective agreement, and the kind of flexibility for meeting during lunch breaks, after hours, or on days off, that was possible for pharmacists and physicians was more difficult for them."

Final Report, Evaluation of the Primary Health Care Collectives Project. (This project, in Edmonton, created six teams of family physicians, pharmacists and home care nurse managers to improve the quality of medication use by high-risk patients/clients in the community.)

The Airdrie Community Health Centre brought together several different programs under the same roof: disease/injury prevention and health promotion services, home care and community rehabilitation programs. These programs exist as separate functional units with different budgets, reporting structures and catchment areas. Professional staff reported to centrally located program managers and directors, and often identified more closely with their discipline than with the centre team. This was not consistent with a primary health care/community health approach to population or community-based planning.

payment and incentives

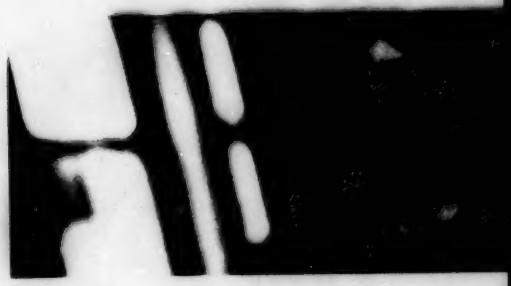
Many necessary elements of primary health care delivery, such as team meetings, are not covered by the fee-for-service payment to physicians. The work on alternative payment plans for physicians was being done at the same time as the primary health care pilot and evaluation projects. In fact, some of the projects have incorporated an alternative payment plan model.

The **Community Outreach in Pediatrics/Psychiatry and Education (COPE) Program** in Calgary has provided pediatric and child psychiatry services to underserved, disadvantaged children in public schools in Calgary's high-risk communities since 1997. The related enhancement/evaluation project found that current billing policies for physicians were a barrier to integrated, team-based and preventative practices on which the program is based. Physicians could only bill for consultations with other health care professionals when the patient was present. As well, medical staff may not receive remuneration for public education, parent education and outreach functions, that are an important part of primary health care.

The **Primary Health Care Collectives Project** identified that their model provided for payment of physicians for collaborative practice activities. This had an impact on the health system, particularly in case conferencing for the monitoring and follow-up of people with complex health needs. In his advice to new collectives, one physician said that it was important to:

> *"...document what you are doing and how much time it takes. I get penalized for taking on tough people...so now we can say this is what it takes and you need to recognize this...Those who want to do it differently are being penalized – a disincentive... the only way to find the answers is to have the data."*
>
> Physician, Primary Health Care Collectives Project

The projects uncovered another disincentive for multi-disciplinary teams within the primary health care environment; namely, that this work was often an add-on to other responsibilities. Current workloads limited the amount of time professionals could devote to activities outside the scope of their regular duties. Staffing shortages exacerbated the problem and left team members little flexibility to manage the changing demands of collaborative care activities.



"Because of the alternative payment plan the physician can participate more fully on a multi-disciplinary team and can focus attention on some of the high-needs population groups that often don't get the kind of clinical time that we would like them to be able to access. I think it's freed our physicians to think a little more broadly about how they can participate on the team and how they can direct their energies to the people with the highest needs."

Marion Relf, Site Director, Northeast Community Health Centre
(The Centre, in Edmonton, provides a unique range of coordinated primary health care services to the surrounding community.)

funding

Short-term project funding, inherent to pilot projects, always presents challenges in evaluating outcomes, recruiting for temporary positions, obtaining and maintaining buy in from stakeholders (including health professionals) and managing the expectations of the community. Understanding these challenges from the outset allowed projects to manage them appropriately.

The Health for All (Metis Settlement) Project in the Lakeland Regional Health Authority added a nurse to four Metis settlements in the region to enhance public health and home care services in those communities. The project had to deal with skepticism from the community about the short-term nature of the project. Many in the settlement felt it was another "band-aid" solution. Through close, collaborative work between the health authority and the settlements, a trusting relationship began to form, as did enthusiasm for the project. The region has since extended the nursing service in the settlements to full-time and added home care responsibilities.

"The Health for All project laid the groundwork in that it allowed the establishment of rapport and the building of the relationships, getting the trust that we needed. Since then all four settlements were eager to get their own settlement nurse."

Lorraine Berube, Public Health Services Leader, The Health for All (Metis Settlement) Project

[solid] ground

The local, regional and provincial environment can have a **profound impact** on **the ease or difficulty** with which primary health care is implemented. The projects identified two elements which significantly influence the development of primary health care:

- stability of the regional health authority; and
- readiness of the community to accept change.

AN ENVIRONMENT OF STABILITY

The relative stability of the boards and executives of regional health authorities played a significant role in the projects, particularly in the planning and program development stages. Maintaining a clear focus and direction, as well as gaining the support of the community and other external stakeholders was easier when the governing board and administrative leads remained the same over the course of the projects.

Changes in leadership in the Lakeland Regional Health Authority created difficulties in the implementation and operation of the **Health for All – Metis Settlement Project**. A major review and restructuring of the health authority occurred at the same time as the project was being developed, creating uncertainty about the future.

The restructuring also caused disruption and confusion at the staff level, and drew managers away from the project to deal with other pressing issues. A number of new players were introduced to the project, including new supervisors for the settlement nurses and a new project leader, none of whom had been involved in the planning stages of the project. Settlement elections resulted in changes in the communities' health representative on the Lakeland Project's Steering Committee. The project, therefore, had difficulty "getting off the ground." However, over time, and with extensive community consultation, a solid and trusting relationship was built between the settlements and the regional health authority, to the degree that the turnaround is recognized as a major success story of the initiative.

Restructuring in the Calgary Regional Health Authority had a significant impact on the **Airdrie Regional Health Centre (ARHC) Evaluation Project**. The change in leadership of the board and executive in the health authority, and an organization-wide restructuring, saw the dissolution of the Community Health Resources Division. The division had acted as a champion for the implementation of a primary health care focus for the multi-use community health centre. The evaluation cited the absence of a common, guiding vision that resulted directly from the re-organization of the health authority.

READINESS FOR CHANGE

A key element of primary health care is the involvement of the community, both in promoting personal responsibility for maintaining good health and in helping to determine the range of health services provided. The nature of this involvement will depend, in part, on the readiness of the community to accept change in health service delivery.

"Each community has its own personality. We made it clear to them that they were going to have different problems, different priorities, and different strategies to deal with. And they were going to make the changes they needed to make at their own pace."

Steve Petz, CEO, East Central Health Authority

The **Brooks Cares Project** was designed to address the increasing health needs associated with population growth in the town of Brooks. A Participatory Action Research (PAR) approach was chosen to help residents identify key initiatives that would improve community and individual health.

Although the project did not proceed as originally intended, the experience was useful in identifying factors that were critical to successfully implementing PAR. Participants came to trust in the PAR process, and strong support for the process developed within one particular community group and the Community Health Council.

"While most people would probably moan and groan about how painful it was to plan, in the end, most would say it was the **most beneficial experience**. It gave us focus, helped to do the assessment, identified gaps, and recognized the unique nature of each community."

Sharon Jeffares, V-P of Health Services,
East Central Health Authority

The primary health care projects identified six success factors in program planning:

- developing a common understanding;
- developing a common vision and goals;
- getting the buy in;
- developing supports for change;
- defining roles and responsibilities; and
- developing an evaluation process.

A COMMON UNDERSTANDING

A key element of success in developing primary health care services is ensuring all stakeholders share a clear understanding of what is involved. A broad and inclusive definition of primary health care and the principles on which it is based must be agreed upon by everyone from the board and executive leadership to the front-line providers and the community at large.

The Northeast Community Health Centre in Edmonton used health determinants (e.g. level of education, employment, income levels) as the basis for a needs assessment of the community. That in turn defined the services to be included in their model. Not everyone appreciated the connection between health determinants and their impact on health, nor that actions or interventions associated with human and social services can be equally as important as the more traditional health services.

"I was phoned and asked why we were permitting a class on English as a Second Language to be held in our community room. The caller questioned what connection it had with health care."

Marion Relf, Site Director, Northeast Community Health Centre

"This was about understanding health and the determinants of health and involving the community and staff in creating a vision beyond what we were doing now to what we could do if we had a common interest."

Sharon Jeffares, V-P of Health Services, East Central Health Authority

A COMMON VISION AND GOAL

Once the stakeholders have established a common understanding of the principles of primary health care, they can begin to develop the vision and goals for their particular primary health care service. Developed collaboratively, the vision and goals should then be continuously reinforced.

During the multi-year planning for the Northeast Community Health Centre in Edmonton, a vision, mission, operating principles and range of services were developed by a team that included community members, Capital Health Authority staff, physicians, educators and independent consultants.

"We are proud to say that our vision has remained virtually unchanged since its inception, and we credit that to the inclusive development process, and commitment to communicating that vision from top to bottom, bottom to top, in the organization. The mission and vision act as the rudder in navigating this ship. They guide the current and future directions of the centre and keep us firmly on course."

Marion Relf, Site Director, Northeast Community Health Centre, Edmonton

THE BUY IN

The importance of collaboration and consultation with all stakeholders in developing primary health care is obvious, but the "when" and the "how" are also critical. Some projects felt that they went out to the community too soon, before they were adequately prepared. Others believed that they involved some stakeholders, notably physicians, too late in the process.

The evaluation of the Airdrie Community Health Centre revealed that community expectations were not aligned with physician expectations. The community's understanding of the type of service that would be provided was firmly entrenched before input from the physicians was sought. The physicians had a different point of view. The result was a need to backtrack, find common ground, and develop a mutually acceptable solution.

In another example, Health Region 5's project involved the provision of services to rural communities through a mobile multi-disciplinary and intersectoral team. Time constraints during the planning phase prohibited the involvement of front-line staff in the process. Staff reported feeling left out of the process and were concerned that their programs were not adequately represented in the project plan. A community development approach was used to engage the staff during the early implementation phase, and a number of the resulting ideas for the project were integrated into the plan. However, this caused some delay in implementation.

The important factor is that change needs to be planned, supported and managed.

"We recognize now that some of the challenges we faced in the implementation of the project could have been avoided if we had had the time to include all relevant stakeholders in the planning process."

Project Coordinator, Health Authority 5

SUPPORTS FOR CHANGE

The move towards primary health care involves changing the way health providers have typically worked. Supports for change may be in the form of:

- **financial resources (examining payment structures for all disciplines involved to see whether they are providing financial incentives for the professional activities necessary for collaboration and integrated services);**
- **human resources (using outside expertise, facilitating multi-disciplinary teams, additional staff to manage increasing workloads);**
- **technical (installing appropriate information systems for sharing patient/client records while maintaining patient/client confidentiality).**

The important factor is that change needs to be planned, supported and managed.

The Lakeland Regional Health Authority had three strategic steps in developing their Integrated Community-based Palliative Care Program (Project): creating a climate for change, building a structure for change and supporting the change. They created the climate for change by making sure all stakeholders understood how the program represented a change from the way things were currently done. Building the structure for change meant standardizing policies and procedures, preparing the necessary tools and developing training manuals. Supporting the change involved ensuring ongoing communication, through networking and meetings with internal and external stakeholders.

"A strong focus on change management, understanding the changes that would take place, and putting resources in place to ease the transition over time helped us build a strong program with positive support from everyone involved."

Chantal Vallee, Regional Palliative Care Coordinator, Lakeland Regional Health Authority

Many of the projects demonstrated it takes time to foster new relationships, accept new responsibilities and adapt to a new way of doing things.

"Build in time for maturation... this is necessary in order to ensure staff are given time to work out processes and procedures within a new environment."

Final report of the Evaluation of the Northeast Community Health Centre, Edmonton

DEFINE ROLES AND RESPONSIBILITIES

"One of the first things about a team is that it's hard for you to make a referral to somebody if you really don't understand what it is they do."

Chris MacFarlane, Executive Director, Alexandra Community Health Centre. (This project was an evaluation of the Centre that has been serving the health needs of residents of Calgary's inner city for 27 years.)

Creating a collaborative environment requires a shift from a system where responsibilities are distinct and separate to one where a variety of providers work together; from a system where roles are clearly understood to one where roles are new or evolving.

"The nurse practitioner had been employed in the clinic in the role of a registered nurse for one year prior to the project implementation. As changes occurred in the proposed project, the physician group in particular was not completely clear about the role of the nurse practitioner. A formal orientation about the nature of the independent practice of a nurse practitioner earlier in the project would have been useful."

Final Evaluation Report of the Calgary Urban Project Society (CUPS) Project. (The CUPS project involved integrating a nurse practitioner into the primary care model developed at this inner-city health centre in Calgary.)

The need to define roles and responsibilities applies as much to governance levels and agencies as it does to providers. Numerous organizations and agencies were involved in the planning and implementation of the Northeast Community Health Centre (NECHC) in Edmonton. A community advisory committee was struck to ensure that the collective voice of the northeastern communities was heard. However, as the planning process evolved, the distinction between the roles of the advisory committee and of the Community Health Councils in the region became blurred. Establishing terms of reference for the advisory committee served to clarify the boundaries.

The Primary Health Care Collectives Project found that facilitation of team-building was instrumental in giving the team members a better understanding of one another's roles and responsibilities. Weekly team meetings helped to achieve this as the project evolved.

"If you leave out home care, you leave out a large part of medication information and context. Our pharmacist had never done a home assessment...I gave her some pointers, including being a guest in their home. The pharmacist said she would never think the same – she will always ask about what is happening in the home, and where they store their pills, etc."

Final Evaluation Report, Primary Health Care Collectives, comment by a home care case manager on understanding and appreciating their role.

We tend to think evaluation is always done at the end of a project. But the primary health care projects found that determining what works well and what needs refinement is only possible when an ongoing process of evaluation is part of the project from the beginning.

DEVELOPING AN EVALUATION PROCESS

We tend to think evaluation is always done at the end of a project. But the primary health care projects found that determining what works well and what needs refinement is only possible when an ongoing process of evaluation is part of the project from the beginning.

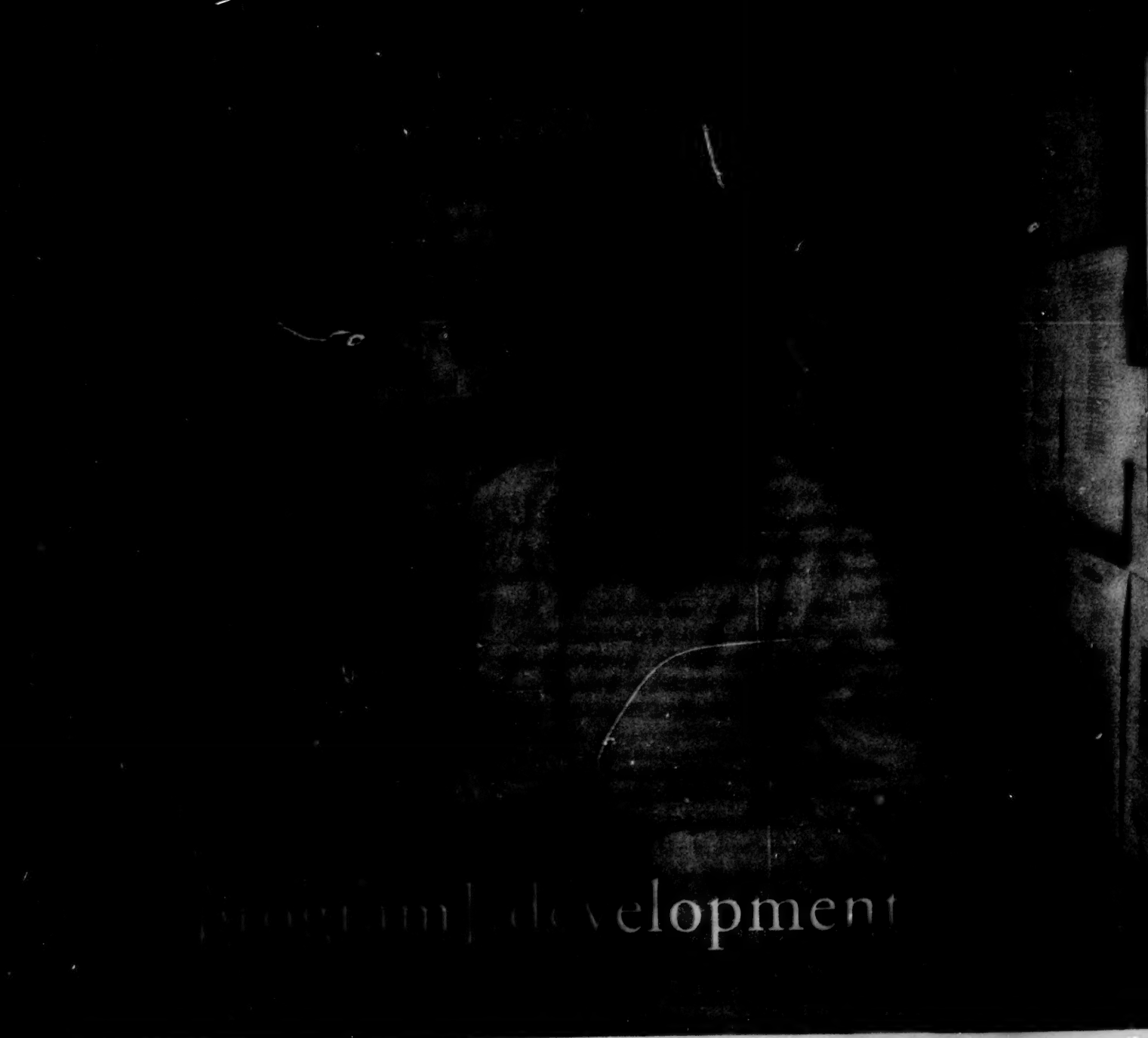
Evaluation of the Northeast Community Health Centre in Edmonton included a formative evaluation of the first 15 months of operation. The Centre also assumed responsibility and secured funding to conduct a three and five-year formative and summative evaluation plan to assess long term outcomes, evaluation of specific services, and the evaluation of an alternative payment plan for physicians.

In the early phase of their project, Health Authority 5 developed a series of evaluation tools, including patient/client satisfaction surveys. Originally, the health providers distributed and collected the surveys. When the project shifted to surveys by self-addressed stamped envelopes, the response rate climbed dramatically.

"Especially in the area of mental health service delivery, we found that clients were much more apt to provide their feedback when they could maintain anonymity."

Project Coordinator, Health Authority 5

In another example, East Central Health Authority credits the involvement of an independent evaluator throughout their project with keeping the project true to its goals and objectives, and with keeping evaluation at the top of everyone's mind as the project progressed.



The programs and services provided in primary health care may include screening, health information, general examinations, treatment for disease, immunization, hearing and eye examinations, prenatal care, nutritional counselling, addiction counselling, laboratory and diagnostic tests, mental health services, drug dispensing and information, and palliative care.

They **require coordination** with community agencies that are appropriate to the needs of the population being served. Programs **must also be sensitive** to the needs of populations from other cultures and who speak other languages.

The primary health care projects identified three basic lessons about program development:

- define the target population;
- conduct a needs assessment: and
- implement strategies to facilitate access.

DEFINE THE TARGET POPULATION

"Our focus is on serving the inner city. The evaluation showed that 30 per cent of the people we see live in the inner city, and another 30 per cent work in the inner city. But another 30 per cent come from all over the region."

Micheline Nimmock, 8th and 8th Health Centre

There are many ways to define a target population – age, specific chronic disease, or geography to name a few. Using only one parameter to define the population may not be sufficient for program development.

The original mandate of the Alexandra Community Health Centre in Calgary was to provide services to the low-income community in the immediate area around the centre. However, over the 27 years that the centre had been in operation, the demographics of the community had dramatically changed. Further, an assessment of the clientele found that a large percentage of patients/clients came from outside the geographic boundaries of the centre. As a result, the health needs of the community being served had to be redefined. Other projects also found their target population to be different than they had originally thought.

"We realized that it wasn't just about serving the people in the four towns, but the folks in neighbouring communities as well. Widening our circle to include those folks in the discussions was a challenge for us, and ultimately, I think, one of our successes."

Sharon Jeffares, V-P Health Services, East Central Health Authority

NEEDS ASSESSMENT

Once the target population has been clearly defined, a thorough needs assessment should be done to provide information vital to developing programs that address and meet the health needs of the population.

The Elnora Primary Health Care Project determined that a primary health care service for their community had to be accessible and affordable. The addition of a nurse practitioner to the primary health care team was deemed appropriate to meet that need.

The nurse practitioner provided basic ambulatory care (examinations, prescribing medications, ordering and interpreting lab results), injury prevention/education and emergency response management. The nurse practitioner was also involved with Well Woman and Well Man clinics, farm safety promotion and education, diabetes support and public education around emergency response.

"The role and responsibilities of the nurse practitioner in this community were developed by the primary health care team in response to expressed needs of the community. These needs were instrumental in defining the working job description of the nurse practitioner."

Yvonne Hoppins, Coordinator, Elnora Community Health Centre

The community or potential patient/client group should be involved in the needs assessment, not only because they can provide a first-hand representation of their needs, but also because early involvement in the process defines their expectations.

Health Authority 5 conducted many meetings with community groups and members when developing the services the multi-disciplinary team would provide. Both pharmacy and remote laboratory services were added to the core team services provided to the communities in response to community input.

"During several of the meetings individuals identified a need to obtain their prescriptions locally. None of the project districts had drugstores. As a result of consulting with the communities, pharmacies became a core team service. The service was extremely well received."

Project Coordinator, Health Authority 5

Speech Language Pathologist, Magda Marais, a member of the rural mobile team that brought a number of health professionals into the heart of rural Alberta

ENSURING ACCESS

Even when a program is developed with a clear understanding of the target population and their needs, access to those services is not a given. The culture, social-economic status, education, literacy and other unique aspects of the community must be taken into account.

The Healthy Families Project in the Capital Health Region partnered with community agencies to reach the target population and inform them about the health services available. The demographics of this population indicated that they were very unlikely to access the health services any other way. The community agencies identified potential candidates for the program and brought the program to a community facility where clients would feel most comfortable. For example, young teen mothers were connected with the Terra Foundation, and Aboriginal parents accessed services from the Broken Arrow Community Health Centre.

"There are three women's shelters in the inner city. The women in these shelters have many health needs, but do not feel safe enough to go out to access services. So we now have a public health nurse who visits the shelters. If the women need to come into the centre for services, we have made arrangements to have them dropped off so that their safety is not compromised."

Micheline Nimmock, 8th & 8th Community Health Centre, Calgary

[implementation]

The skills required for planning may differ significantly from the skills required in the implementation of a primary health care service. Some overlap between the membership of the **planning team** and the **implementation team** supports continuity.

While the appropriate mix of skills is critical, the attitude of the providers is equally important. Providers with an open attitude, flexibility with regard to role boundaries, and a strong desire to collaborate with others will likely flourish in a primary health care setting.

The projects also concluded that successful implementation requires:

- building a strong team;
- training and education;
- access to information; and
- good communication and program marketing.

BUILDING THE TEAM

The members of a primary health care team will vary depending on the type of service provided. The **Integrated Community-based Palliative Care Project** in the Lakeland Regional Health Authority included a team of palliative care physicians and nurses, other health providers and volunteers. The **Community Outreach in Pediatrics/ Psychiatry and Education (COPE) Program** (Project) team included psychiatrists, teachers, pediatricians and family physicians.

While the appropriate mix of skills is critical, the attitude of the providers is equally important. Delivering health care in a team environment can be a difficult change for many health professionals. Providers with an open attitude, flexibility with regard to role boundaries, and a strong desire to collaborate with others will likely flourish in a primary health care setting.

"The facilitator helped us put together interview questions (for potential team members), such as, 'Why are you motivated to participate?' We stuck to it until the last team, and that was the team that ended up having the most difficulty."

Dr. Karen Farris, Principal Investigator, Primary Health Care Collectives

The successful integration of the nurse practitioner role in the CUPS Community Health Centre in Calgary was due in part to the willingness of the team to collaborate and to redefine roles and responsibilities. The relationship between the nurses and the nurse practitioner was strengthened through open discussion, a stated distinction between, and support for, all nursing roles. The support of the centre's physicians and community pharmacists was also vital for the health team's success.

"I love it because of the multi-disciplinary nature of the clinic…because the nurse practitioner can see the more straightforward cases, that frees me up to spend time with the complex patients."

Dr. Gisela MacPhail, CUPS physician

They recommended the same training for all members of the team, regardless of profession or medical background.

TRAINING AND EDUCATION

Continued education for the staff reinforces the focus on new processes or procedures that may develop as part of primary health care service delivery.

In the Lakeland Integrated Community-based Palliative Care Project, the palliative care nurse consultant and the physician consultant were mentored by experienced palliative care experts from the Capital Health Region's Palliative Care Program. The nurse consultant and physician consultant also participated in the PallCare EdNet Project – a collaborative project of the palliative care divisions of the Universities of Alberta and Calgary, the community health division of Grant MacEwan College, the Faculty of Nursing at the University of Lethbridge, and the Palliative Care Program of the Chinook Health Region. This six- to eight-week web-based course focused on pain and symptom management, psychological distress, communication with terminally ill patients and their families, and psycho-social issues.

"Providing ongoing and diverse education opportunities for all caregivers, whether health professionals or volunteers, has been integral in enhancing the quality of palliative care in this region."

Chantal Vallee, Regional Palliative Care Coordinator,
Lakeland Palliative Care Program

The Shared Mental Health Care in Primary Care Practice Project in the Calgary Regional Health Authority saw a need for training to accommodate the multi-disciplinary nature of the teams. They recommended the same training for all members of the team, regardless of profession or medical background.

"It would be advantageous for future integration to formalize the mix of professionals through training programs. It is very important, however, that the training setting include opportunities for both medical and non-medical health professionals. A family practice clinic with training opportunities for residents in psychiatry as well as training opportunities for nurses, psychologists, social workers and other mental health students would be advantageous."

Evaluation Report, Shared Mental Health Care in Primary Health Care Project
(This demonstration project in the Calgary Regional Health Authority examined how mental health services might be better delivered within physician practices and offices.)

ACCESS TO INFORMATION

Access to information is a critical part of working in a primary health care environment, because of the collaborative process and multi-disciplinary teams that characterize that environment. It is equally important that everyone on the team involved in the delivery of care have the same access to client information, and that they establish mechanisms for sharing diagnostic and treatment information.

Developing an electronic common health (patient/client) record is a complicated process that involves hardware and software integration issues, as well as confidentiality issues.

Many of the projects found other ways to share information. Some used paper records or forms common to all members of the team; others used case management meetings and internet communication,

The Lakeland Regional Health Authority's **Palliative Care Program** implemented a "Communication Passport," a tool aimed at increasing communication between service providers. Relevant information about an individual's care, including pain, symptoms, changes in medication and appointments, was included in the passport.

The **Northeast Community Heath Centre** in Edmonton instituted a common health record (non-electronic) that provided the basis for sharing client information among disciplines. The **Community Outreach in Pediatrics/Psychiatry and Education (COPE) Program** (Project) in Calgary made use of the family liaison worker to coordinate and share information among the members of the team as appropriate and with attention to confidentiality issues.

"The important factor is that some mechanism exist so that all members of the team have access to the same client information, and are able to share the information they collect, while maintaining confidentiality and reducing the number of times a client has to repeat information."

Marion Relf, Site Director, Northeast Community Health Centre, Edmonton

People can only access programs and services if they know they exist.

COMMUNICATION AND PROGRAM MARKETING

People can only access programs and services if they know they exist. Mechanisms for informing the target population must be built in to program design and take into account the population being addressed. Communications vehicles and messages targeted to seniors will be quite different from those targeted to young teen mothers.

Health Authority 5 (HA5) developed a comprehensive social marketing program for their program. Communication with the target population was critical not only to ensure awareness of the new service, but also to distinguish the new service from existing programs in the districts. They developed a series of marketing and communication materials (newsletters, a newspaper ad, direct mail pieces, a program profile booklet), all of which had a common look, creating a recognizable identity for the project. Over time, "word-of-mouth" communication, always an effective communication tool in small communities, took over. Finally, the communication plan for the project also addressed the needs of the HA5 health professionals, advisory committee members, project professionals and virtual team members.

"Communication became one of the most important factors in the project. It helped to maintain the sense of team by providing a way of keeping everyone in the loop. It also was integral to increasing awareness in the community of the services they could access."

Project Coordinator, Health Authority 5

[where to] from here?

Recognizing the challenges involved in implementing primary health care, one participant noted that the projects were **an opportunity for learning** and that although the projects themselves came to an end, the lessons they learned **serve as a beginning** for other primary health care initiatives.

Individually, the 27 Alberta primary health care projects are disseminating their key learning and experience in a variety of ways. Alberta Health and Wellness is also sharing the learning widely through the development of a number of publications. These publications include a series of booklets, newsletters and a website at www.health.gov.ab.ca/key/phc/index.htm.

"We built it on the fly. If we had to do it over again, we would do it differently. We would have a clearer vision up front. We would do a lot more advance work with key players in the community. We would make sure we had the board on side; that they clearly understood what we were trying to accomplish and why. We would integrate physicians into the process earlier on. We would have the staff in place that could make it happen…It's so critical to have everyone on side. Because if it's not understood and accepted by the region and the community, it just isn't going to work."

Steve Petz, CEO, East Central Health Authority

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